

Washington State Health Care Authority

Medicaid Provider Guide

Home Health Services
(Acute Care Services)
[WAC 182-551-2000 through 2220](#)



Washington State
Health Care Authority

A Billing Instruction

About This Publication

This guide supersedes all previous Home Health Services Medicaid Provider Guides published by the Health Care Authority (the Medicaid Agency).

Effective Date

The effective date of this publication is: **01/01/13**.

What Has Changed?

Reason for Change	Effective Date	Page No.	Subject	Change
PN 12-104	1/1/2013	All	Housekeeping	Added automated Table of Contents, updated hyperlinks and bookmarks; removed references to “Agency’s designee;” clarified which Agency (Medicaid or home health) in all instances; updated form names; updated titles
		14	Covered – Skilled Therapies for Clients 21 Years of Age and Older	Added “Clients 19 and 20 Years of Age in MCS/ADATSA”
		15	Using Timed/Untimed CPT codes	Added “Therapy codes including evaluations must be billed as described in this billing instruction. Failure to bill correctly will result in denials or recoupment.”
		25	LE/ETR - What forms are required?	Removed HCA form 13-756 and added HCA form 13-835.
		28	Documentation Requirements	Added the following to the first paragraph, “...and report to OASIS (Medicare’s Outcome and Assessment Information Set).”

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How Can I Get Medicaid Agency Provider Documents?

To download and print the Medicaid Agency's provider guides and provider notices, go to the Medicaid Agency's [Provider Publications](#) website.


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Alert! The page numbers in this table of contents are now “clickable”—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks  on the left side of the document. (If you don’t immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

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Important Contacts

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Medicaid Agency's Resources Available .
Finding out about payments, denials, claims processing, or Medicaid Agency contracted managed care organizations	
Electronic or paper billing	
Finding Medicaid Agency documents (e.g., provider guides, provider notices, fee schedules)	
Private insurance or third-party liability, other than Agency-contracted managed care	
Sending medical verification of visits, plan of care, and change orders during focused review periods	Health Care Benefits and Utilization Management Home Health Program Manager PO Box 45506 Olympia WA 98504-5506
Finding a list of Interpreter Agencies in my area	Visit the Medicaid Agency's Medicaid Interpreter Services website.
Home health policy or medical review questions	Home Health Program Coverage Home Health Program Manager Phone: (360) 725-1570 FAX requests to: 1-866-668-1214
Long-Term Care (LTC) needs	Home Health needing LTC Exceptions FAX requests to: 1-866-668-1214
Home and Community Services (HCS)	Look in the front of the local telephone book or call the State Reception Line 1-800-422-3263 and ask for local HCS number.

Home Health (Acute Care Services)

Topic	Contact Information
Division of Developmental Disabilities (DDD) phone numbers	Region 1 1-800-462-0624 Region 2 1-800-822-7840 Region 3 1-800-788-2053 Region 4 1-800-314-3296 Region 5 1-800-248-0949 Region 6 1-800-339-8227
Pharmacy Authorization	See the Medicaid Agency's Resources Available .
Contacting ADSA	If you do not know the local telephone number, you may call: State Reception Line: 1-800-422-3263
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extension, the following documentation is "Required": <ul style="list-style-type: none"> • A completed, TYPED General Information for Authorization form (HCA 13-835). This request form MUST be the initial page when you submit your request. • A completed Home Health and Hospice (including PPC) Authorization Request form (HCA 13-847), and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Medicaid Agency's Resources Available .
Contacting the Medicaid Agency regarding requests for noncovered services	For all written requests, fax a completed, typed General Information for Authorization form (HCA 13-835), as well as a completed Home Health and Hospice (including PCC) Authorization Request form (HCA 13-847), to 1-866-668-1214. See the Medicaid Agency's Resources Available .

Definitions

This section defines terms specific to these billing instructions. Please refer to the Medicaid Agency's [Medical Assistance Glossary](#) for a more complete list of definitions.

Acute care – Care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist. [[WAC 182-551-2010](#)]

Authorized Practitioner – An individual authorized to sign a home health plan of care.

Brief Skilled Nursing Visit – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

- An injection;
- Blood draw; or
- Placement of medications in containers.

[[WAC 182-551-2010](#)]

Case Manager – A social worker or a nurse assigned Aging and Disabilities Services Administration (ADSA), the Department of Social & Health Services to manage and coordinate the client's case.

Case Resource Manager (CRM) – An individual who meets with the family and assesses the client's DDD needs, develops a plan with the family and helps connect to appropriate resources assigned by the Division of Developmental Disabilities (DDD).

Chronic care – Long-term care for medically stable clients. [[WAC 182-551-2010](#)]

Expedited prior authorization (EPA) - means the process for obtaining authorization for selected healthcare services in which providers use a set of numeric codes to indicate to the Medicaid Agency which acceptable indications, conditions, or defined criteria are applicable to a particular request for authorization. EPA is a form of "prior authorization.

Full skilled nursing services – A registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

- Observation;
- Assessment;
- Treatment;
- Teaching;
- Training;
- Management; and
- Evaluation.

[[WAC 182-551-2010](#)]

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence.

[[WAC 182-551-2010](#)]

Home Health Aide – An individual registered or certified as a nursing assistance under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

[[WAC 182-551-2010](#)]

Home Health (Acute Care Services)

Home Health Aide services – Services provided by a home health aide when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by, or under contract with, a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners, and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's conditions and needs, and completing appropriate records. [[WAC 182-551-2010](#)]

Home Health skilled services – Skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a Medicare certified home health agency with a current Core Provider Agreement. [[WAC 182-551-2010](#)].

Long-term care – A generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the Aging and Disabilities Services Administration (ADSA) or Division of Developmental Disabilities (DDD) with the Department of Social and Health Services. [[WAC 182-551-2010](#)]

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by the Medicaid Agency for specific services, supplies, or equipment.

Plan of Care (POC) – (Also known as “plan of treatment” [POT]). A written document that is established and periodically reviewed and signed by both a physician and a home health agency provider.

The plan describes the home health care to be provided at the client's residence. [[WAC 182-551-2010](#)]

Residence - A client's home or private place of living. [[WAC 182-551-2010](#)]
(See When Does the Medicaid Agency Pay for Covered Home Health Services for information on clients in residential facilities whose home health services are not covered through the Medicaid Agency's home health program.)

Review Period – The three-month period the Medicaid Agency assigns to a home health agency, based on the address of the home health agency's main office, during which the Medicaid Agency reviews all claims submitted by that home health agency. [Refer to [WAC 182-551-2010](#)]

Revised Code of Washington (RCW) - Washington State laws.

Specialized therapy – Skilled therapy services provided to clients that include: physical, occupational, and speech/audiology services. [[WAC 182-551-2010](#)].

Supervision - Authoritative procedural guidance given by a qualified person who assumes the responsibility for the accomplishment of a function or activity and who provides initial direction and periodic inspection of the actual act of accomplishing the function or activity.

Usual & Customary Fee – The rate that may be billed to the Medicaid Agency for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Home Health Services

What Is the Purpose of the Home Health Program?

[Refer to [WAC 182-551-2000](#)]

The purpose of the Medicaid Agency's Home Health program is to provide equally effective, less restrictive quality care to the client in the client's residence when the client is not able to access the medically necessary services in the community or in lieu of hospitalization.

Home health skilled services are provided for **acute**, intermittent, short-term, and intensive courses of treatment.

Note: See [What Home Health Services Are Not Covered](#) for information on chronic, long-term maintenance care.

Who Is an Eligible Home Health Provider?

[Refer to [WAC 182-551-2200](#)]

The following may contract with the Medicaid Agency to provide health services through the home health program, subject to the restrictions or limitations in this billing instruction and applicable published Washington Administrative Code (WAC).

A home health agency that:

- Is Title XVIII (Medicare) certified;
- Is Department of Health (DOH) licensed as a home health agency;
- Continues to meet DOH requirements;
- Submits a completed, signed Core Provider Agreement to the Medicaid Agency; and
- Has a home health taxonomy on their provider file.

A registered nurse (RN) who:

- Is prior authorized by the Medicaid Agency to provider intermittent nursing services when no home health agency exists in the area a client resides;
- Is unable to contract with a Medicare-certified home health agency;
- Submits a completed, signed Core Provider Agreement to the Medicaid Agency; and
- Has an RN home health taxonomy on their provider file.

Important! Please notify the Medicaid Agency **within ten days** of any change in name, address, or telephone number (see [Important Contacts](#)).

Client Eligibility

Who Is Eligible? [Refer to [WAC 182-551-2020\(1\)](#)]

Please see the Medicaid Agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Note: Refer to the [Scope of Healthcare Services Table](#) for an up-to-date listing of Benefit Service Packages.

Restrictions [[WAC 182-551-2020\(2\)](#)]

The Medicaid Agency does not cover home health services under the Home Health program for clients in the CNP-Emergency Medical Only

Managed Care Clients [Refer to [WAC 182-551-2020\(1\)](#)]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a Medicaid Agency-contracted managed care organization (MCO), managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

All medical services covered under a Medicaid Agency-contracted MCO must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Medicaid Agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the Medicaid Agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Dually Enrolled Clients

Dually enrolled (Medicare-Medicaid) clients and **Medicare only** clients may be eligible to receive certain home and community based services under the Community Options Program Entry System (COPES) or Title XIX Personal Care programs. These programs are administered under the Department of Social and Health Services' - Aging and Disabilities Services Administration (ADSA). Please contact your local ADSA field office for more information on these programs (see [Important Contacts](#)).

Dually enrolled clients who do NOT meet Home Bound status criteria per Medicare are eligible for Home Health through Medicaid. Providers need to indicate "NOT HOMEBOUND" on the UB-04 box 80 REMARKS.

Coverage/Limits

When Does the Medicaid Agency Pay for Covered Home Health Services? [Refer to [WAC 182-551-2030](#)]

The Medicaid Agency pays for covered home health services provided to eligible clients when all of the criteria listed in this section are met. Reimbursement is subject to the restrictions or limitations in these billing instructions and other applicable published Washington Administrative Code (WAC).

Home health skilled services provided to eligible clients must:

- Meet the definition of “acute care”;
- Provide for the treatment of an illness, injury, or disability;
- Be medically necessary (see [Definitions](#));
- Be reasonable, based on community standard of care, in amount, duration, and frequency;
- Be provided under a Plan of Care (POC). Any statement in the POC must be supported by documentation in the client’s medical records; and
- Be used to prevent placement in a more restrictive setting.

In addition, the client’s medical records must justify the medical reason(s) that the services should be provided in the client’s residence instead of a physician’s office, clinic, or other outpatient setting. This includes justification for services for a client’s medical condition that requires teaching that would be most effectively accomplished in the client’s home on a short-term basis.

- Be provided in the client’s residence. The Medicaid Agency does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client’s place of residence.
 - ✓ **Residential facilities** contracted with the state to provide limited skilled nursing services are **not reimbursed** separately for those same services under the Medicaid Agency’s Home Health program.

Home Health (Acute Care Services)

- ✓ It is the home health agencies responsibility to request coverage for a client when the services are not available to the client in the community or through LTC.
 - ✓ If the client meets the criteria in these billing instructions for therapy services, the Medicaid Agency will evaluate the need after receiving the request.
 - ✓ Refer to Aging and Disabilities Services Administration's (ADSA) [Residential Care Services](#) web page.
- Be provided by a home health agency that is Title XVIII (Medicare) certified and state-licensed.

Refer to [WAC 182-551-2100\(1\)](#)

The Medicaid Agency covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider.

The Medicaid Agency evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in [WAC 182-501-0165](#).

Covered – Acute Nursing Services

[Refer to [WAC 182-551-2100\(2\)\(3\)](#)]

The Medicaid Agency covers the following home health acute care skilled nursing services:

1. **Full Skilled Nursing Services** - that require the skills of a Registered Nurse (RN) **or** a Licensed Practical Nurse (LPN) under the supervision of a Registered Nurse, if the services involve **one or more** of the following:
 - a. Observation (approximately 3 weeks);
 - b. Assessment (approximately 3 weeks);
 - c. Treatment;
 - d. Teaching (approximately 3 days);
 - e. Training (approximately 4 visits unless client remains unstable); and
 - f. Management; and
 - g. Evaluation.

Home Health (Acute Care Services)

2. **Brief Skilled Nursing Visit** - only if one of the following activities is performed during the visit:
- An injection;
 - Blood draw; or
 - Placement of medications in containers (e.g., envelopes, cups, medisets).

Note: Use revenue code 580 when billing for a brief skilled nursing visit.

The Medicaid Agency limits skilled nursing visits provided to eligible clients to **two (whether they are brief or full) per day**.

3. **Home Infusion Therapy** - only if the client:
- Is willing and capable of learning and managing the client's infusion care; or
 - Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

Note: The Medicaid Agency does not reimburse for administration of IV therapy through the Home Health program. The Medicaid Agency does reimburse for the teaching of IV therapy and skilled observation of IV site through the Home Health program.

Note: All other infusion therapy related services must be billed on a CMS-1500 claim form using the [Home Infusion Therapy/Parenteral Nutrition Program Medicaid Provider Guide](#).

Note: Although Medicaid Agency clients may have a paid caregiver who is willing and capable of performing the skilled task, as a paid caregiver they may not be paid for this service. The client may want to be involved in self-directed care.

4. **Infant Phototherapy** – for an infant diagnosed with hyperbilirubinemia:
- When provided by a Medicaid Agency-approved* infant phototherapy agency; and
 - For up to **five (5)** skilled nursing visits per infant.

Note: If the infant's mother is enrolled in a Medicaid Agency-contracted managed care organization (MCO) at the time of the birth, you must receive approval from the MCO listed on the mother's eligibility check. **Do not bill the Medicaid Agency for these services.**

Additional Information Required in the Plan of Care (See [Criteria for High-Risk Obstetrical](#)):

- a. Infant's name, mother's name, and ProviderOne Client ID(s);
- b. Information regarding the infant's medical condition, and the family's ability to safely provide home phototherapy;
- c. Name of hospital where infant was born and discharge date;
- d. Visit notes that include family teaching and interventions; and
- e. Bilirubin levels.

***How do I become a Medicaid Agency-approved infant phototherapy agency?**

1. Be a Medicaid and Medicare certified Home Health agency;
2. Have an established phototherapy program; and
3. Submit to the Medicaid Agency for review, all of the following:
 - a. Six months of documented phototherapy services delivered for infants;
 - b. A written policy for home phototherapy submitted to the Medicaid Agency for review that includes guidelines, procedures, and job descriptions verifying experience in pediatrics and maternal child health;
and
 - c. Three letters of recommendation from pediatricians who have utilized your program.

Note: The Medicaid Agency will not cover infant phototherapy, **unless** your agency has a pre-approval letter on file from the Medicaid Agency noting that you are an approved infant phototherapy agency. Refer to the Medicaid Agency's [Wheelchairs, Durable Medical Equipment \(DME\), and Supplies Medicaid Provider Guide](#) for equipment component.

5. **Limited High-Risk Obstetrical Services:**

- a. For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;
- b. For up to **three** home health visits per pregnancy, if:
 - i. Enrollment in or referral to the following providers of First Steps has been verified:
 - A. Maternity Support Services (MSS); **or**
 - B. Maternity Case Management (MCM); **and**
 - ii. The visits are provided by a registered nurse who has either:
 - A. National perinatal certification; or
 - B. A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

Note: Use revenue code **0551** with diagnosis codes V23 or 630 through 670 when billing for skilled high-risk obstetrical nursing care visits in the home setting.

Note: The Medicaid Agency does not reimburse for high-risk obstetrics if the registered nurse has not met the criteria listed above.

See the Medicaid Agency's Specific [Criteria for High-Risk Obstetrical](#)

Covered - Specialized Therapy for Clients 20 Years of Age and Younger

[Refer to [WAC 182-551-2110\(1\)\(2\)](#)]

For eligible clients 20 years of age and younger, the Medicaid Agency covers **specialized therapy services** which includes physical, occupational, or speech/audiology services:

The Medicaid Agency reimburses for specialized therapy services only when the client is **not able to access these services in their local community**. The Medicaid Agency limits specialized therapy visits to one per client, per day, per type of specialized therapy. Documentation must justify the skilled need of the visit.

Under specialized therapy, a client's residence may include a residential care facility with skilled nursing services available.

Note: The maximum number of visits allowed is based on appropriate medical justification. The Medicaid Agency does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s). If the client requires more than one therapist in the residence on the same day, the Medicaid Agency requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Covered - Skilled Therapies for Clients 21 Years of Age and Older and Clients 19 and 20 Years of Age in MCS/ADATSA

The following benefit limits for outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy) apply to clients 21 years of age and older and to clients 19 through 20 years of age in MCS/ADATSA. These benefit limits are **per client, per calendar year** regardless of setting (home health, outpatient hospital and freestanding therapy clinics.) Authorization is not required.

- Physical therapy: 24 units (equals approximately 6 hours);
- Occupational therapy: 24 units (equals approximately 6 hours);
- Speech therapy: 6 units (equals a total of 6 untimed visits).

Addressing Limits

The limits for therapies are **per client, per calendar year**. In order to ensure payment, please follow these guidelines:

- Bill in a timely manner. Claims will pay in date of service order. If a claim comes in for a previous date of service, the system will automatically pay the earlier date and recoup or adjust the later date.
- Contact the Medicaid Agency to check on limits, by submitting a service limit request to Medical Administration Customer Service Center (MACSC) by using the [on-line request form](#).
- Please consult the [ProviderOne Billing and Resource Guide](#) Section: Client Eligibility, Benefit Packages, and Coverage Limits.

Home Health (Acute Care Services)

Please see [expedited prior authorization](#) (EPA) to obtain additional visits for qualifying conditions. If the client does not have a qualifying condition as outlined in the EPA section, the Home Health agency needs to request a limitation extension from the Medicaid Agency.

Using Timed/Untimed CPT® codes

For specialized therapies:

- Each 15 minutes of timed CPT® codes equals one unit;
- Each non-timed CPT® code equals one unit, regardless of how long the procedure takes.

Therapy codes, including evaluations, must be billed as described in this billing instruction. Failure to bill correctly will result in denials or recoupment.

Modality	Home Health Revenue Codes	Home Health Procedure Codes	Description	Modifiers
PT	0421	G0151	Services performed by a qualified physical therapist in the home health or hospice setting each 15 minutes.	GP
OT	0431	G0152	Services performed by a qualified occupational therapist in the home health or hospice setting each 15 minutes.	GO
ST	0441	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	GN

If the client's outpatient rehabilitation services maximum benefit limit has been reached (initial units and any additional EPA units, when appropriate), a provider may request authorization for a limitation extension from the Medicaid Agency.

Therapy Evaluations for Clients 21 Years of Age and Older

The Medicaid Agency pays for therapy evaluations for physical therapy (PT), occupational therapy (OT), and speech therapy (ST). Evaluations do not count toward the limit, but are subject to annual limits. Please see [Therapy Evaluation Codes](#) Table. Providers bill with revenue code, the CPT code, and the appropriate modifier. Providers must request authorization for a limitation extension if additional evaluations are needed.

Therapy Evaluation Codes

Modality	Evaluation Revenue Codes	Evaluation CPT Codes	Description	Modifiers	Limitations
PT	0424	97001	Physical Therapy Evaluation	GP	1 per client, per calendar year
		97002	Physical Therapy Re-evaluation at time of discharge	GP	1 per client, per calendar year
		97542	Wheelchair management	GP	1 per client, per calendar year. Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
OT	0434	97003	Occupational Therapy Evaluation	GO	1 per client, per calendar year
		97004	Occupational Therapy Re-evaluation at time of discharge	GO	1 per client, per calendar year
		97542	Wheelchair management	GO	1 per client, per calendar year. Assessment is limited to four 15-min units per assessment. Indicate on claim wheelchair assessment
ST	0444	92506	Speech Language Pathology Evaluation	GN	1 per client, per calendar year
		S9152	Speech Language Pathology Re-evaluation at time of discharge	GN	1 per client, per calendar year
		92610	Evaluate swallowing function (this one would not have any limits)	GN	No Limit
		92597	Oral speech device eval	GN	No Limit

Expedited Prior Authorization (EPA) - Additional Units for Clients 21 and Older

When a client meets the EPA criteria listed in [Authorization](#) for additional benefit units of outpatient rehabilitation, providers must use the expedited prior authorization (EPA) process. When a client's situation does not meet the conditions for EPA, a provider must request prior authorization.

EPA may be requested once, per client, per calendar year, per each therapy type.

Home Health Aide Services [Refer to [WAC 182-551-2120\(1\)\(2\)\(3\)](#)]

1. The Medicaid Agency limits home health aide visits to **one per day**.
2. The Medicaid Agency reimburses for home health aide services only when the services are provided under the supervision of, and in conjunction with practitioners who provide:
 - a. Skilled nursing services; or
 - b. Specialized therapy services.
3. The Medicaid Agency covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every 14 days to monitor or supervise home health aide services, with or without the presence of the home health aide. The Medicaid Agency does not reimburse for services covered by another state administration such as LTC services, COPES, CHORE, or CAP services.

Documentation in the client's file must justify the need for the home health aide visits.

Note: Contact the client's case manager/case resource manager to see if the client is eligible for, or is already receiving, LTC services, COPES, CHORE, or CAP services.

Telemedicine

[Refer to [WAC 182-551-2125](#)]

The Medicaid Agency covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis(es) where there is a high risk of sudden change in medical condition which could compromise health outcomes.

Providers must use revenue code 0559 when billing the Medicaid Agency for home health services delivered through telemedicine.

What Does the Medicaid Agency Pay for?

The Medicaid Agency pays for one telemedicine interaction, per eligible client, per day based on the ordering licensed practitioner's home health plan of care.

Requirements for Payment

To receive payment for the delivery of home health services through telemedicine, the services must involve:

- A documented assessment, identified problem, and evaluation which includes:
 - ✓ Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also includes assessment of response to previous changes in the plan of care; and
 - ✓ Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care; and
- Implementation of a documented management plan through one or more of the following:
 - ✓ Education regarding medication management as appropriate, based on the findings from the telemedicine encounter;
 - ✓ Education regarding other interventions as appropriate to both the patient and the caregiver;
 - ✓ Management and evaluation of the plan of care including changes in visit frequency or the addition of other skilled services;
 - ✓ Coordination of care with the ordering licensed provider regarding findings from the telemedicine encounter;
 - ✓ Coordination and referral to other medical providers as needed; and
 - ✓ Referral to the emergency room as needed.

What Does the Medicaid Agency Not Pay for?

The Medicaid Agency does not pay for the purchase, rental, repair, or maintenance of telemedicine equipment and associated costs of operation of telemedicine equipment.

Prior Authorization

The Medicaid Agency does not require prior authorization for the delivery of home health services through telemedicine.

What Home Health Services Are Not Covered?

[Refer to [WAC 182-551-2130](#)]

The Medicaid Agency does not cover the following home health services under the Home Health program, unless otherwise specified:

1. Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the Department of Social and Health Services, Aging and Disabilities Services Administration (ADSA) or Division of Developmental Disabilities (DDD).

The Medicaid Agency may consider requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ADSA or DDD to implement a long-term care skilled nursing plan or specialized therapy plan.

On a case-by-case basis, the Medicaid Agency may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until an ADSA or DDD long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in these billing instructions and other published WACs.

Home Health Agencies

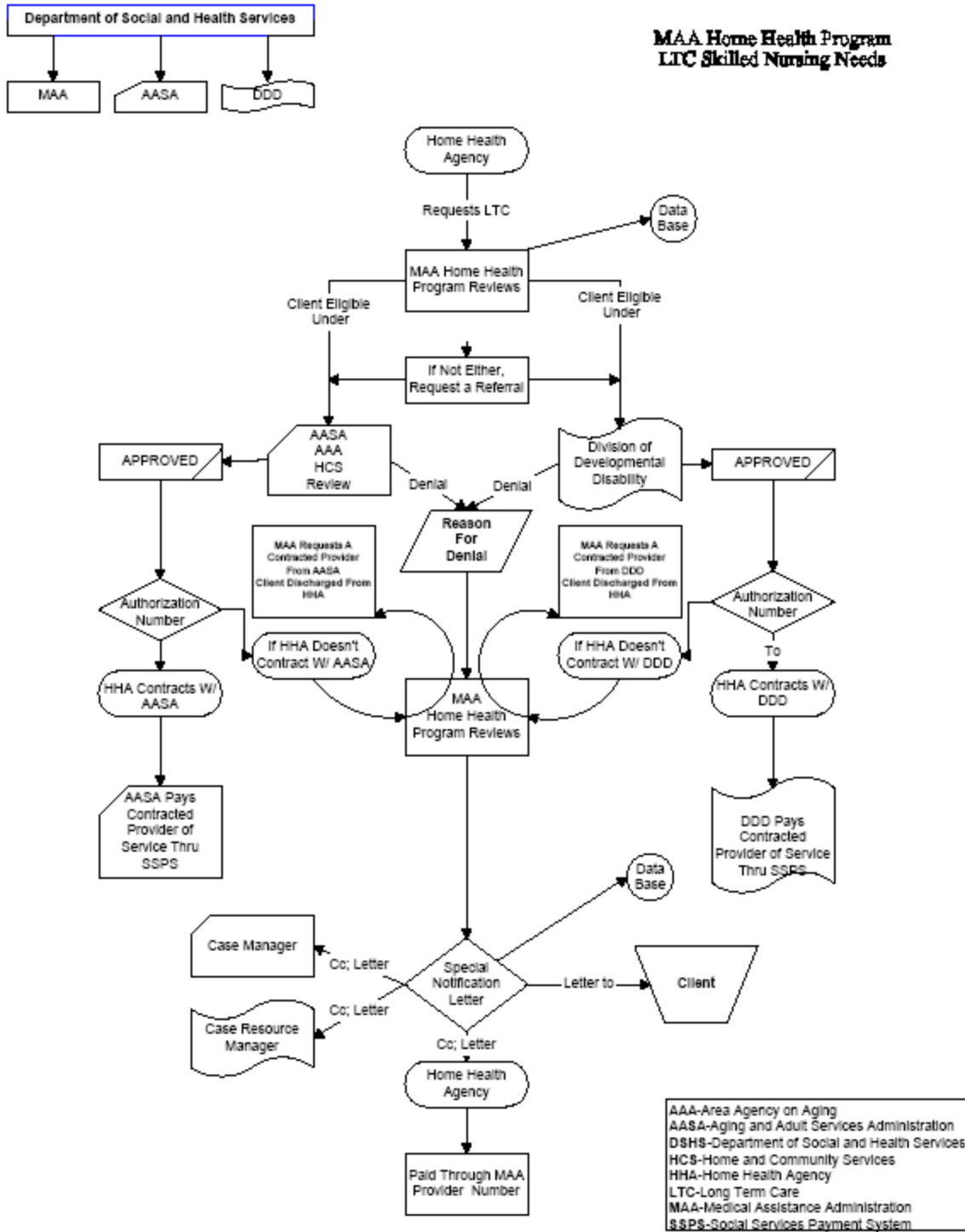
- The client must have a stable, chronic skilled nursing need.
- The client's skilled nursing need cannot be met in the community (e.g., the client is unable to access outpatient services in the community);
- The home health provider must **contact the Medicaid Agency and request coverage** through the home health program;

The Medicaid Agency will first contact the client's ADSA or DDD case manager to see if long-term care skilled nursing services are accessible in the community or through ADSA or DDD.

If there are no other options, the Medicaid Agency will send a notification letter to the client, Home Health agency, and case manager notifying them that the chronic, long-term care skilled nursing visits will be reimbursed through the Medicaid Agency for a limited time until a long-term care plan is in place.

See LTC Skilled Nursing Needs flow chart on next page

Long Term Care Skilled Nursing Needs Flow Chart



What Is Not Covered? (continued)

2. Social work services;
3. Psychiatric skilled nursing services;
4. Pre and postnatal skilled nursing services, except those listed under Covered – Acute Nursing Services;
5. Well-baby follow-up care;
6. Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing available;
7. Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services;
8. Home health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change, unless the client meets the applicable criteria at the beginning of this section);
9. Skilled nursing visits for a client when a home health agency cannot **safely** meet the medical needs of that client within home health services program limitations;

Examples:

- a. The client or caregiver is not willing and/or capable of managing the client's infusion therapy care; or
 - b. A client requires daily visits in excess of program limitations.
10. More than one of the same type of specialized therapy and/or home health aide visit per day. **The Medicaid Agency does not reimburse for duplicate services** for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).
 11. More than one of the same type of specialized therapy and/or home health aide visit per day. **The Medicaid Agency does not reimburse for duplicate services** for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).
 12. Any home health services covered by another state administration such as LTC services, COPES, CHORE, or CAP services.

Home Health (Acute Care Services)

13. Home health visits made without a written physician order, unless the verbal order is:
 - a. Documented prior to the visit; and
 - b. The document is signed by the physician within 45 days of the order being given.
14. Additional administrative costs billed above the visit (these costs are included in the visit rate and will not be paid separately).

The Medicaid Agency evaluates a request for any service that is listed as noncovered under the provisions of [WAC 182-501-0165](#).

Requests must include the following:

1. Name of agency and NPI;
2. Client's name and ProviderOne Client ID;
3. Copy of the plan of care; and
4. Explanation of client-specific medical necessity.

Send requests for noncovered services to the Medicaid Agency (see [Important Contacts](#)). See [Authorization](#) for information regarding Limitation Extensions.

Authorization

The Medicaid Agency evaluates a request for covered services that are subject to limitations or restrictions, and approves such services **beyond** those limitations or restrictions when medically necessary, under the standard for covered services in [WAC 182-501-0165](#).

Note: A provider may request an exception to rule (ETR) for a noncovered service as described in [WAC 182-501-0160](#).

Limitation Extension and Exception to Rule (ETR)

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when a provider can verify that it is medically necessary to provide **more units of service** than allowed in the Medicaid Agency's Washington Administrative Code (WAC) and billing instructions.

How do I get LE or ETR authorization?

LE or ETR authorization may be obtained by using the written/fax authorization process.

Your request must include the following:

1. Name of agency and NPI;
2. Client's name and ProviderOne Client ID;
3. Copy of the plan of care;
4. Explanation of client-specific medical necessity to exceed limitation or why it is an exception to rule.

Clients who have Medicare as their primary insurance must meet Medicare's definition of "[home bound](#)" for Home Health services.

Note: Please indicate on your request if the client does not meet Medicare's definition of "home bound" when submitting the ETR request.

Clients who don't meet Medicare's definition of [home bound](#) may be eligible for Medicaid to cover Home Health services as an Exception to Rule (ETR). These clients must still meet Medicaid's Home Health coverage requirements listed above.

What forms are required?

The Medicaid Agency requires both of the following forms to request LE or ETR authorization:

- Home Health & Hospice Authorization Request form, [13-847](#); and
- General Information for Authorization form, [13-835](#).

Please send or fax your completed forms to the Medicaid Agency (see [Important Contacts](#)).

Note: Please see the Medicaid Agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

Expedited Prior Authorization (EPA)

EPA is designed to eliminate the need for written authorization from the Medicaid Agency. The Medicaid Agency establishes clinical criteria for the provider to apply and determine if the client's condition is medically necessary and qualifies for additional services. The Medicaid Agency assigns each criteria set a specific numeric code.

Enter the appropriate 9-digit EPA code on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically.

EPA numbers and/or limitation extensions (LE) do not override the client's eligibility or program limitations. Not all eligibility groups receive all services.

Note: The Medicaid Agency denies claims submitted without a required EPA number.

The Medicaid Agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how EPA criteria were met and make this information available to the Medicaid Agency upon request. If the Medicaid Agency determines the documentation does not meet the criteria, the claim will be denied.

Expedited Prior Authorization Guidelines

Documentation

The provider must verify medical necessity for the services billed using the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the Medicaid Agency request. If the Medicaid Agency determines the documentation does not meet EPA criteria, the claim will be denied.

Note: When medical necessity for the service cannot be established using the EPA clinical criteria, prior authorization is required.

Which Services Require EPA?

EPA #	EPA	Description	Billing Code(s)	Modifier
870000008	Lymphedema Therapy	Lymphedema management	0421-G0151; 0431 - G0152	GO, GP
870000009	CNS Injury (Brain Injury - Traumatic and non-Traumatic, CVA - new onset)	Cerebral vascular accident with residual functional deficits within the past twenty-four months;	0421-G0151; 0431 - G0152; 0441 - 92507	GN, GP & GO
870000010	Swallowing	Swallowing deficits due to injury or surgery to face, head, or neck;	0431 - G0152, 0441 - 92507	GN, GO
870000011	Botox	As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the Agency	0421-G0151; 0431 - G0152	GP & GO
870000012	Spinal Injury/Surgery (para, quad & spinal surgery- new onset)	Spinal cord injury resulting in paraplegia or quadriplegia within the past twenty-four months;	0421-G0151; 0431 - G0152; 0441 - 92507	GN, GP & GO

Home Health (Acute Care Services)

EPA #	EPA	Description	Billing Code(s)	Modifier
870000013	Major Joint Surgery	Major joint surgery - partial or total replacement only;	0421-G0151; 0431 - G0152	GP & GO
870000014	Muscular/skeletal, other (open fractures, ORIF)	New onset muscular-skeletal disorders such as complex fractures which required surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg foot, knee, or hip); Reflex sympathetic dystrophy;	0421-G0151; 0431 - G0152; 0441 - 92507	GN, GP & GO
870000015	Burns/Wounds (complex)	Acute, open, or chronic non-healing wounds; Burns - second or third degree only	0421-G0151; 0431 - G0152; 0441 - 92507	GN, GP & GO
870000016	Neurological Disorders - Adult Onset	New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));	0421-G0151; 0431 - G0152; 0441 - 92507	GN, GP & GO
870000017	Speech deficit	due to injury or surgery to face, head, or neck	0441 - 92507	GN

Provider Requirements

Documentation Requirements

The Medicaid Agency requires home health providers to keep individual medical records for each client and report to Medicare's OASIS (Outcome and Assessment Information Set).

Documentation That Must be Kept in the Client's Medical Record but Does NOT Have to be Sent to the Medicaid Agency Unless Requested

The individual client medical record must comply with community standards of practice, and must include documentation of:

- Visit notes for every billed visit;
- Supervisory visits for home health aide services as described in [Coverage/Limits](#);
- All medications administered and treatments provided;
- All physician orders, new orders, and change orders, with notation that the order was received prior to treatment;
- Signed physician new orders and change orders;
- Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;
- Interdisciplinary and multidisciplinary team communications;
- Inter-agency and intra-agency referrals;
- Medical tests and results;
- Pertinent medical history; and
- Notations and charting with signature and title of writer.

What Documentation Must Be Kept in the Visit Notes?

The provider must document at least the following in the client's medical record:

- Skilled interventions per the POC;
- Client response to POC;
- Any clinical change in the client status;
- Follow-up interventions specific to a change in status with significant clinical findings; and
- Any communications with the attending physician.

In addition, when appropriate:

- Any teachings, assessment, management, evaluation, client compliance, and client response;
- **Weekly** documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;
- If a client's wound is not healing, the client's physician has been notified, the client's wound management program has been appropriately altered, and; if possible, the client has been referred to a wound care specialist; and
- The client's physical system assessment as identified in the POC.

Insufficiently Documented Home Health Care Service

[Refer to [WAC 182-551-2220\(6\)](#)]

The Medicaid Agency may take back or deny payment for any insufficiently documented home health care service when the Agency determines that:

- The service did not meet the conditions listed in [Coverage/Limits](#); or
- The service was not in compliance with program policy.

Plan of Care Requirements

For any delivered home health service to be payable, the Medicaid Agency requires home health providers to develop and implement an individualized Plan of Care (POC) for the client.

Note: Home health providers are required to comply with audits and/or site visits to ensure quality of care and compliance with state rule. All documentation in the client record, including the signed Plan of Care, must be made available to the Medicaid Agency upon request. (Refer to [WAC 182-502-0020](#).)

About the Plan of Care (POC)

The POC must:

- Be documented in writing and be located in the client's home health medical record;
- Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;

Home Health (Acute Care Services)

- Reflect the physician's orders and client's **current** health status;
- Contain specific goals and treatment plans;
- Be reviewed and revised by the licensed registered nurse or licensed therapist and the client's physician at least every 60 calendar days;
- Signed by the physician within 45 days of the verbal order;
- Returned to the home health agency's file; and
- Be available to the Medicaid Agency staff or its designated contractor(s) on request.

What Must Be Included in the Plan of Care?

The provider must include in the POC all of the following:

- The client's name and date of birth;
- The start of care;
- The date(s) of service;
- The primary diagnosis (the diagnosis that is **most related to the reason** the client qualifies for home health services) and is the reason for the visit frequency;
- All secondary medical diagnosis including date(s) of onset (**O**) or exacerbation (**E**);
- The prognosis;
- The type(s) of equipment required;

Note: Durable Medical Supplies & Equipment (MSE) must be billed on a separate CMS-1500 claim form using an NPI and taxonomy for which DME/MSE services are allowed. Do not bill Durable MSEs on a Home Health claim.

- A description of each planned service and goals related to the services provided;
- Specific procedures and modalities;
- A description of the client's mental status;
- A description of the client's rehabilitation potential;

Home Health (Acute Care Services)

- A list of permitted activities;
- A list of safety measures taken on behalf of the client; and
- A list of medications which indicates:
 - ✓ Any new (N) prescription; and
 - ✓ Which medications are changed (C) for dosage or route of administration.

Important Information to Send with the Plan of Care if not Already Included

The provider must include in, or attach to the POC:

- Client's address including name of the residential care facility where the client is residing (if applicable).
- A description of the client's functional limits and the effects;
- Documentation that justifies why the medical services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting;
- Significant clinical findings;
- Dates of recent hospitalization;
- Notification to the home health agency's designated case manager of admittance;
- A discharge plan, including notification to the home health agency's designated case manager of the planned discharge date and client disposition at time of discharge; and
- A short summary of what is happening with the client or what has happened since last review.

Notifying Clients of Their Rights (Advance Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions. Keep a copy of the written information in the client's record.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Criteria for High-Risk Obstetrical

Hyperemesis Gravidarum

GOALS:

1. Assess the client's condition;
2. Teach the client to help maintain her pregnancy to term; **and**
3. Reduce the signs and symptoms of fluid, nutritional and electrolyte imbalances.

Home care for the client with hyperemesis gravidarum (HG) may be initiated when weight loss and significant metabolic changes require fluid and nutritional replacement therapy that can be managed in the home setting. The client or caregiver must be willing and capable of learning and managing the client's intravenous therapy.

Therapeutic Skilled Nursing Services may be initiated with the obstetrical provider's request for care. These services are designed to reinforce the clinic, hospital and/or provider's teaching. The nursing services assist the client and family in managing her care in the home and may include:

- Education about the factors that may contribute to hyperemesis gravidarum, such as stress and coping with pregnancy;
- Education on the symptoms related to dehydration and electrolyte disturbances and their effects on the mother and fetus (e.g., parenteral fluids and nutritional supplements);
- Assurance that the client is able to follow the treatment regimen (parenteral fluids and nutritional supplements) and comply with medications (antiemetics);
- Reinforcement of the obstetrical provider's plan of care, including the plan for resuming oral intake;
- Demonstration of the ability to manage and administer the infusion treatment ordered by the obstetrical provider (hydration or total parenteral nutrition); **and**
- Education concerning when to notify the obstetrical provider.

Documentation in the client record must include, but is not limited to, the following:

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of hyperemesis gravidarum (HG);
- Evaluation of clinical status of mother and fetus, including maternal weight and vital signs;
- Evaluation of the obstetrical provider's plan of care;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family regarding management of the prescribed care for a medically high-risk pregnancy.

Gestational Diabetes

GOALS:

1. Assess the client's condition;
2. Provide adequate support and education to help the client reduce symptoms of gestational diabetes; **and**
3. Maintain the pregnancy to planned delivery.

Whenever possible, education should be given at suitable diabetic teaching centers. A more complete and comprehensive training is available at these sites. A few cases may merit skilled nursing services. For example, skilled nursing may be provided to a client who is unable to get to a diabetic educational center or to a client who has special learning needs.

Therapeutic Skilled Nursing Services may be initiated when there is a documented reason for teaching gestational diabetes management in the home. It should reinforce the obstetrical provider's or clinic's teaching.

Therapeutic skilled nursing services may include:

- Assuring the client understands her plan of care;
- Managing insulin injections;
- Diet and exercise;
- Demonstrating and teaching the blood glucose monitoring techniques, and the necessary times to test and documentation of testing results;
- Explaining the differences between normal and abnormal blood glucose test results;
- Explaining protocols for results of abnormal blood glucose, ketones and protein in the urine;
- Planning with the client for emergency treatment of hyper/hypoglycemia; **and**
- Explaining when to notify the obstetrical provider about symptoms.

Documentation in the client record must include, but is not limited to, the following:

- Estimated date of confinement;
- Gravity/parity;
- History of symptoms of gestational diabetes;
- Evaluation of clinical status of mother and fetus;
- Evaluation of obstetrical provider's Plan of Care;
- Rationale for in-home gestational diabetes education;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family in the management of the prescribed treatment for a medically high-risk pregnancy.

Preterm Labor

GOALS:

1. Assess the client's condition; **and**
2. Provide adequate support and education to help the client maintain her pregnancy to term.

Home care for preterm labor (PTL) symptoms may be initiated with the obstetrical provider's prescription for care and when there is an assurance of a viable newborn.

Preventive Services may be initiated between 20-25 weeks when an eligible client has a history of preterm births and/or has a multiple gestation and has been started on oral tocolytics.

Therapeutic Skilled Nursing Services may be initiated between 25-36 weeks gestation or birth (whichever comes first) or until the tocolytics are discontinued. Cervical changes should be documented at the start of care.

Skilled nursing care reinforces the medical protocol and assures that:

- The client comprehends and is compliant with the medication;
- The client can manage the restricted activity plan;
- The plan of care is coordinated with Maternity Support Services so that childcare and transportation services are readily available, if needed; **and**
- The client education includes fetal movement count, signs and symptoms of preterm labor and when to notify obstetrical provider.

Documentation in the client record must include, but is not limited to, the following:

- Estimated date of confinement;
- Gravidity/parity;
- History of pre-term labor (PTL);
- Documented cervical change;
- Obstetrical provider's plan for care;
- Assessment of maternal and fetal clinical status;
- Medications;
- Referral to a Maternity Support Service (MSS) provider; **and**
- Education of the client and family in management of the prescribed care for a high-risk pregnancy.

Pregnancy-Induced Hypertension

GOALS:

1. Assess the client's condition;
2. Provide adequate support and education to help the client reduce symptoms of pregnancy induced hypertension; **and**
3. Maintain the pregnancy to term.

Home Health (Acute Care Services)

Home care for Pregnancy-Induced Hypertension (PIH) may be initiated after 20 weeks gestation when:

- Blood pressure readings have increased by 30 mm Hg (systolic pressure)/15 mm Hg (diastolic pressure) over the baseline; **and**
- The client has accompanying symptoms (e.g., lab changes, proteinuria, and a weight gain greater than two lbs./week). Late signs/symptoms may include hyperreflexia, epigastric pain and/or visual changes.

Therapeutic Skilled Nursing Services may be initiated at the prescribing medical provider's request and documented signs and symptoms indicate the PIH may be safely managed in the home setting **and** the:

- Client requires bed rest with bathroom privileges.
- Client understands and is able to comply with bed rest/reduced activities in the home.
- Assessment includes vital signs, fetal heart tones, fundal height, deep tendon reflexes, and a check for proteinuria, edema and signs and symptoms of PIH.
- Client and family members receive education on:
 - ✓ How to monitor blood pressure;
 - ✓ How to evaluate urine for protein; **and**
 - ✓ When to notify the obstetrical provider.
- Reinforce education client received from her obstetrical provider's office. This may include:
 - ✓ Etiology and diagnosis of PIH;
 - ✓ Treatment and rationale;
 - ✓ Nutrition needs;
 - ✓ Need for rest;
 - ✓ Client monitoring of uterine and fetal activity; **and**
 - ✓ The role of medication in reducing symptoms (if provided).
- The plan of care is coordinated with the MSS provider so that childcare and transportation services are readily available.

Home Health (Acute Care Services)

Documentation in the client record must include but is not limited to the following:

- Estimated date of confinement;
- Gravidity/parity;
- History of symptoms of PIH;
- Evaluation of clinical status of mother and fetus;
- Obstetrical provider's plan for care;
- Frequency of clinic visits;
- Activity level;
- Medication, if prescribed;
- Referral to a Maternity Support Service provider; **and**
- Education of the client and family on management of the prescribed care.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Medicaid Agency [ProviderOne Billing and Resource Guide](#). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Medicaid Agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Note: When billing on the UB-04 claim form. Services provided on different days are required to be listed separately along with revenue code, procedure code, modifier, dates of service and units.

Medical Review Rebilling:

Prior to rebilling, please cross off all lines on the claim form that the Medicaid Agency has already paid.

ATTN: Special Handle
Home Health Services Program Manager
PO Box 45506
Olympia, WA 98504-5506

Fee Schedule

You may view the Medicaid Agency's [Home Health Services Fee Schedule](#).

Completing the UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the [National Uniform Billing Committee](#).